DIVISION OF SERVICES FOR PEOPLE WITH DISABILITIES

FORM 1-8

INCIDENT REPORT FORM

PERSON'S ID: 0___ ___ ___ ___ ___ ___ ___ ___	PERSON'S NAME:	
TODAY'S DATE: _____/_____/_____ MM DD YY	DATE INCIDENT STARTED: ____/____/____ MM DD YY	TIME INCIDENT STARTED: _____ AM/PM
YOUR NAME:	DATE INCIDENT ENDED: ____/____/____ MM DD YY	TIME INCIDENT ENDED: _____ AM/PM
YOUR TITLE:	YOUR PHONE NUMBER: ( )	
PROVIDER NAME:	PROVIDER SITE ADDRESS:	City:
NUMBER OF PEOPLE INVOLVED (INCLUDING PERSON IN SERVICES LISTED ABOVE):		

NAMES and ROLES OF OTHERS INVOLVED or WITH PERTINENT INFORMATION, INCLUDING HEALTH CARE PROVIDERS, IF ANY:
(DO NOT INCLUDE PERSON IN SERVICES LISTED ABOVE):

NAME:	ROLE:
NAME:	ROLE:
NAME:	ROLE:
WHERE DID INCIDENT TAKE PLACE?	Provider Site Listed Above Day Program School Friend's Home Relative's Home Other Location (Describe Briefly):

ACTION TAKEN?

MEDICAL PROFESSIONAL NOTIFIED?	Yes No	Name: Title: Phone:
PERSON HOSPITALIZED?	Yes No	Hospital's Name: Phone:
POLICE NOTIFIED?	Yes No	Date: ____/____/_____ Time:_____ AM / PM
APS or CPS NOTIFIED?	Yes No	Date: ____/____/____ Time: _____AM / PM

TYPE OF INCIDENT?

INJURY	Who Was Injured? Person in Services Another/Other Person(s) in Services Staff Other: Who caused the injury? Person in Services Another Person in Services Staff Other: Body part(s) injured: Severity/Treatment:
ABUSE	Who was abused? Person in Services Another Person in Services Staff Other: Who caused the abuse? Person in Services Another Person in Services Staff Other: Type of Abuse/Exploitation: Physical Sexual Emotional Neglect Financial Abuse was: Observed Suspected Severity/Treatment:
CRIMINAL ACT	Type of Act:
DRUG/ALCOHOL	Incident Overdose Drug/Alcohol involved: Severity/Treatment:
Med Error *(Resulting in Medical Procedure)*	Medication(s) involved: Severity/Treatment:
Missing Person	Date Last Seen: ____/____/_____ Time Last Seen:_____ AM / PM Where last seen? Date Found/Returned: ____/____/_____ Time Found/Returned:_____ AM / PM
SEIZURE[1]	Duration: Brief Description of Event:
RESTRAINT[2] Authorized by: Name:_____ Title:_____	Cause: Aggression Self-Injurious Behavior (SIB) Other: Number of Minutes Person was Restrained:
Property Destruction[2]	Item(s) Destroyed: Cost to repair/replace? $_____.____ Owner(s) of Item(s) destroyed:
OTHER INCIDENT	Please provide brief description:

[1] **If person has a diagnosis of Seizure Disorder, a monthly summary of seizures may be used instead of this form.**

[2]**If person destroys property or is restrained more than once a month, a monthly summary of incidents may be used instead of this form.**

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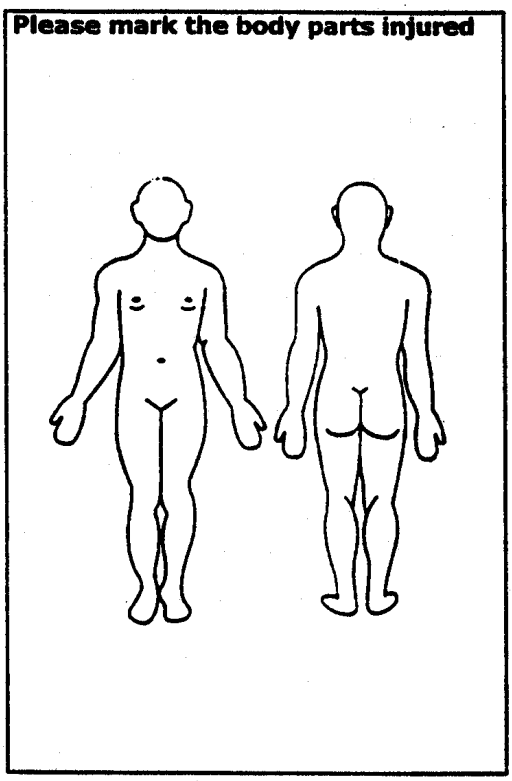
Describe Incident in Detail;
Include How Each Person Was Involved:



Provider Signature:	**Title:**

Support Coordinator Recommendation / Follow-Up:
(Attach APS or CPS Referral Sheet and Final Outcome of Investigation)

Support Coordinator Signature:	**Date Notified:**	**Today's Date:**